HOUSE BILL No. 1537

DIGEST OF INTRODUCED BILL

Citations Affected: IC 4-21.5-2-6; IC 4-22-2-37.1; IC 6-3.1-31; IC 12-7-2; IC 12-31; IC 27-8-5; IC 27-13-7-3; IC 31-19-26.

Synopsis: Indiana health care program. Provides a tax credit for certain small employers. Creates a health care program administered by a health care corporation (corporation) to provide health coverage for all residents. Allows the corporation to adopt emergency rules effective until sine die adjournment of the succeeding general assembly if the corporation determines implementation of the program according to the statute is impossible. Requires all residents to have health coverage. Requires payment by the county office of family and children or the department of child services of the costs of certain health related adoption subsidies. Makes a determination by the department of child services with respect to subsidies subject to administrative review. Makes an appropriation.

Effective: July 1, 2007; January 1, 2008.

Reske

January 23, 2007, read first time and referred to Committee on Insurance.

Introduced

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

HOUSE BILL No. 1537

A BILL FOR AN ACT to amend the Indiana Code concerning human services and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 4-21.5-2-6, AS AMENDED BY P.L.234-2005, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) This article does not apply to the formulation, issuance, or administrative review (but does, except as provided in subsection (b), apply to the judicial review and civil enforcement) of any of the following:

(1) Except as provided in IC 12-17.2-4-18.7 and IC 12-17.2-5-18.7, **and other than a determination made under IC 31-19-26-3,** determinations by the division of family resources and the department of child services.

(2) Determinations by the alcohol and tobacco commission.

(3) Determinations by the office of Medicaid policy and planning concerning recipients and applicants of Medicaid. However, this article does apply to determinations by the office of Medicaid policy and planning concerning providers.

(4) A final determination of the Indiana board of tax review.

(b) IC 4-21.5-5-12 and IC 4-21.5-5-14 do not apply to judicial

review of a final determination of the Indiana board of tax review.

SECTION 2. IC 4-22-2-37.1, AS AMENDED BY P.L.47-2006, SECTION 2, AS AMENDED BY P.L.91-2006, SECTION 2, AND AS AMENDED BY P.L.123-2006, SECTION 12, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 37.1. (a) This section applies to a rulemaking action resulting in any of the following rules:

(1) An order adopted by the commissioner of the Indiana department of transportation under IC 9-20-1-3(d) or IC 9-21-4-7(a) and designated by the commissioner as an emergency rule.

(2) An action taken by the director of the department of natural resources under IC 14-22-2-6(d) or IC 14-22-6-13.

(3) An emergency temporary standard adopted by the occupational safety standards commission under IC 22-8-1.1-16.1.

(4) An emergency rule adopted by the solid waste management board under IC 13-22-2-3 and classifying a waste as hazardous.

(5) A rule, other than a rule described in subdivision (6), adopted by the department of financial institutions under IC 24-4.5-6-107 and declared necessary to meet an emergency.

(6) A rule required under IC 24-4.5-1-106 that is adopted by the department of financial institutions and declared necessary to meet an emergency under IC 24-4.5-6-107.

(7) A rule adopted by the Indiana utility regulatory commission to address an emergency under IC 8-1-2-113.

(8) An emergency rule adopted by the state lottery commission under IC 4-30-3-9.

(9) A rule adopted under IC 16-19-3-5 that the executive board of the state department of health declares is necessary to meet an emergency.

(10) An emergency rule adopted by the Indiana finance authority under IC 8-21-12.

(11) An emergency rule adopted by the insurance commissioner under IC 27-1-23-7.

(12) An emergency rule adopted by the Indiana horse racing commission under IC 4-31-3-9.

(13) An emergency rule adopted by the air pollution control board, the solid waste management board, or the water pollution control board under IC 13-15-4-10(4) or to comply with a deadline required by federal law, provided:

(A) the variance procedures are included in the rules; and

(B) permits or licenses granted during the period the emergency rule is in effect are reviewed after the emergency rule expires.

(14) An emergency rule adopted by the Indiana election commission under IC 3-6-4.1-14.

(15) An emergency rule adopted by the department of natural resources under IC 14-10-2-5.

(16) An emergency rule adopted by the Indiana gaming commission under *IC 4-32.2-3-3(b),* IC 4-33-4-2, IC 4-33-4-3, or IC 4-33-4-14.

(17) An emergency rule adopted by the alcohol and tobacco commission under IC 7.1-3-17.5, IC 7.1-3-17.7, or IC 7.1-3-20-24.4.

(18) An emergency rule adopted by the department of financial institutions under IC 28-15-11.

(19) An emergency rule adopted by the office of the secretary of family and social services under IC 12-8-1-12.

(20) An emergency rule adopted by the office of the children's health insurance program under IC 12-17.6-2-11.

(21) An emergency rule adopted by the office of Medicaid policy and planning under IC 12-15-41-15.

(22) An emergency rule adopted by the Indiana state board of animal health under IC 15-2.1-18-21.

(23) An emergency rule adopted by the board of directors of the Indiana education savings authority under IC 21-9-4-7.

(24) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-34 **(repealed).**

(25) An emergency rule adopted by the department of local government finance under IC 6-1.1-4-33 **(repealed).**

(26) An emergency rule adopted by the boiler and pressure vessel rules board under IC 22-13-2-8(c).

(27) An emergency rule adopted by the Indiana board of tax review under IC 6-1.1-4-37(l) **(repealed)** or an emergency rule adopted by the department of local government finance under IC 6-1.1-4-36(j) **(repealed)** or IC 6-1.1-22.5-20.

(28) An emergency rule adopted by the board of the Indiana economic development corporation under IC 5-28-5-8.

(29) A rule adopted by the department of financial institutions under IC 34-55-10-2.5.

(30) A rule adopted by the Indiana finance authority:

(A) under IC 8-15.5-7 approving user fees (as defined in IC 8-15.5-2-10) provided for in a public-private agreement

under IC 8-15.5;

(B) under IC 8-15-2-17.2(a)(10):

(i) establishing enforcement procedures; and

(ii) making assessments for failure to pay required tolls;

(C) under IC 8-15-2-14(a)(3) authorizing the use of and establishing procedures for the implementation of the collection of user fees by electronic or other nonmanual means; or

(D) to make other changes to existing rules related to a toll road project to accommodate the provisions of a public-private agreement under IC 8-15.5.

(31) An emergency rule adopted by the Indiana health coverage corporation under IC 12-31-2-3.

(b) The following do not apply to rules described in subsection (a):

(1) Sections 24 through 36 of this chapter.

(2) IC 13-14-9.

(c) After a rule described in subsection (a) has been adopted by the agency, the agency shall submit the rule to the publisher for the assignment of a document control number. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The publisher shall determine the ~~*number of copies*~~ *format* of the rule and other documents to be submitted under this subsection.

(d) After the document control number has been assigned, the agency shall submit the rule to the ~~*secretary of state*~~ *publisher* for filing. The agency shall submit the rule in the form required by section 20 of this chapter and with the documents required by section 21 of this chapter. The ~~*secretary of state*~~ *publisher* shall determine the ~~*number of copies*~~ *format* of the rule and other documents to be submitted under this subsection.

(e) Subject to section 39 of this chapter, the ~~*secretary of state*~~ *publisher* shall:

(1) accept the rule for filing; and

(2) ~~*file stamp and indicate*~~ *electronically record* the date and time that the rule is accepted. ~~*on every duplicate original copy submitted.*~~

(f) A rule described in subsection (a) takes effect on the latest of the following dates:

(1) The effective date of the statute delegating authority to the agency to adopt the rule.

(2) The date and time that the rule is accepted for filing under subsection (e).

(3) The effective date stated by the adopting agency in the rule.

(4) The date of compliance with every requirement established by law as a prerequisite to the adoption or effectiveness of the rule.

(g) Subject to subsection (h), IC 14-10-2-5, IC 14-22-2-6, IC 22-8-1.1-16.1, and IC 22-13-2-8(c), and except as provided in subsections (j), ~~*and*~~ (k), ~~*and*~~ *(l),* **and (m),** a rule adopted under this section expires not later than ninety (90) days after the rule is accepted for filing under subsection (e). Except for a rule adopted under subsection (a)(13), (a)(24), (a)(25), or (a)(27), the rule may be extended by adopting another rule under this section, but only for one (1) extension period. The extension period for a rule adopted under subsection (a)(28) may not exceed the period for which the original rule was in effect. A rule adopted under subsection (a)(13) may be extended for two (2) extension periods. Subject to subsection (j), a rule adopted under subsection (a)(24), (a)(25), or (a)(27) may be extended for an unlimited number of extension periods. Except for a rule adopted under subsection (a)(13), for a rule adopted under this section to be effective after one (1) extension period, the rule must be adopted under:

(1) sections 24 through 36 of this chapter; or

(2) IC 13-14-9;

as applicable.

(h) A rule described in subsection (a)(6), (a)(8), (a)(12), or (a)(29) expires on the earlier of the following dates:

(1) The expiration date stated by the adopting agency in the rule.

(2) The date that the rule is amended or repealed by a later rule adopted under sections 24 through 36 of this chapter or this section.

(i) This section may not be used to readopt a rule under IC 4-22-2.5.

(j) A rule described in subsection (a)(24) or (a)(25) expires not later than January 1, 2006.

(k) A rule described in subsection (a)(28) expires on the expiration date stated by the board of the Indiana economic development corporation in the rule.

(l) A rule described in subsection (a)(30) expires on the expiration date stated by the Indiana finance authority in the rule.

(m) A rule described in subsection (a)(31):

(1) expires on the date that the regular session of the general assembly immediately succeeding the effective date of the rule adjourns sine die; and

(2) may be renewed for one (1) extension period, which expires on the date that the regular session of the general

assembly immediately succeeding the session of the general assembly described in subdivision (1) adjourns sine die.

SECTION 3. IC 6-3.1-31 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2008]:

Chapter 31. Small Employer Health Benefit Tax Credit

Sec. 1. As used in this chapter, "pass through entity" means:

(1) a corporation that is exempt from the adjusted gross income tax under IC 6-3-2-2.8(2);

(2) a partnership;

(3) a limited liability company; or

(4) a limited liability partnership.

Sec. 2. As used in this chapter, "state tax liability" means a taxpayer's total tax liability that is incurred under:

(1) IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax);

(2) IC 6-5.5 (the financial institutions tax); and

(3) IC 27-1-18-2 (the insurance premiums tax);

as computed after the application of the credits that under IC 6-3.1-1-2 are to be applied before the credit provided by this chapter.

Sec. 3. As used in this chapter, "taxpayer" means a small employer (as defined in IC 12-31-1-16) that has any state tax liability.

Sec. 4. A taxpayer is entitled to a credit against the taxpayer's state tax liability for a taxable year in an amount equal to fifty percent (50%) of the costs incurred by the taxpayer during the taxable year for coverage under a health benefit plan (as defined in IC 12-31-1-9) provided to employees of the taxpayer during the taxable year.

Sec. 5. If a pass through entity is entitled to a credit under section 4 of this chapter but does not have state tax liability against which the tax credit may be applied, a shareholder, partner, or member of the pass through entity is entitled to a tax credit equal to:

(1) the tax credit determined for the pass through entity for the taxable year; multiplied by

(2) the percentage of the pass through entity's distributive income to which the shareholder, partner, or member is entitled.

Sec. 6. (a) If the credit provided by this chapter exceeds the taxpayer's state tax liability for the taxable year for which the credit is first claimed, the excess may be carried forward to

succeeding taxable years and used as a credit against the taxpayer's state tax liability during those taxable years. Each time that the credit is carried forward to a succeeding taxable year, the credit is to be reduced by the amount that was used as a credit during the immediately preceding taxable year.

(b) A taxpayer is not entitled to any carryback or refund of any unused credit.

Sec. 7. To receive the credit provided by this chapter, a taxpayer must claim the credit on the taxpayer's state tax return or returns in the manner prescribed by the department. The taxpayer shall submit to the department all information that the department determines is necessary for the calculation of the credit provided by this chapter.

SECTION 4. IC 12-7-2-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 18.5. "Authorization", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-1.**

SECTION 5. IC 12-7-2-25.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 25.2. "Carrier", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-2.**

SECTION 6. IC 12-7-2-34.2, AS ADDED BY P.L.217-2005, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 34.2. "Commissioner":

(1) for purposes of IC 12-12-8, has the meaning set forth in IC 12-12-8-1.5; **and**

(2) for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-3.

SECTION 7. IC 12-7-2-43.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 43.5. "Corporation", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-4.**

SECTION 8. IC 12-7-2-75.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 75.5. "Eligible health benefit plan", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-5.**

SECTION 9. IC 12-7-2-76, AS AMENDED BY P.L.145-2006, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 76. (a) "Eligible individual", for purposes of IC 12-10-10, has the meaning set forth in IC 12-10-10-4.

(b) "Eligible individual" has the meaning set forth in IC 12-14-18-1.5 for purposes of the following:

(1) IC 12-10-6.
(2) IC 12-14-2.
(3) IC 12-14-18.
(4) IC 12-14-19.
(5) IC 12-15-2.
(6) IC 12-15-3.
(7) IC 12-16-3.5.
(8) IC 12-20-5.5.

(c) "Eligible individual", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-6.

SECTION 10. IC 12-7-2-77.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 77.2. "Enrollee", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-7.**

SECTION 11. IC 12-7-2-91 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 91. "Fund" means the following:

(1) For purposes of IC 12-12-1-9, the fund described in IC 12-12-1-9.
(2) For purposes of IC 12-13-8, the meaning set forth in IC 12-13-8-1.
(3) For purposes of IC 12-15-20, the meaning set forth in IC 12-15-20-1.
(4) For purposes of IC 12-17-12, the meaning set forth in IC 12-17-12-4.
(5) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-3.
(6) For purposes of IC 12-18-4, the meaning set forth in IC 12-18-4-1.
(7) For purposes of IC 12-18-5, the meaning set forth in IC 12-18-5-1.
(8) For purposes of IC 12-19-7, the meaning set forth in IC 12-19-7-2.
(9) For purposes of IC 12-23-2, the meaning set forth in IC 12-23-2-1.
(10) For purposes of IC 12-23-18, the meaning set forth in IC 12-23-18-4.
(11) For purposes of IC 12-24-6, the meaning set forth in IC 12-24-6-1.
(12) For purposes of IC 12-24-14, the meaning set forth in IC 12-24-14-1.
(13) For purposes of IC 12-30-7, the meaning set forth in

IC 12-30-7-3.

(14) For purposes of IC 12-31, the meaning set forth in IC 12-31-1-8.

SECTION 12. IC 12-7-2-102.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 102.5. "Health benefit plan", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-9.**

SECTION 13. IC 12-7-2-131.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 131.1. "Minimum coverage", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-10.**

SECTION 14. IC 12-7-2-143.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 143.2. "Premium assistance payment", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-11.**

SECTION 15. IC 12-7-2-143.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 143.3. "Premium contribution payment", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-12.**

SECTION 16. IC 12-7-2-146 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 146. "Program" refers to the following:

(1) For purposes of IC 12-10-7, the adult guardianship services program established by IC 12-10-7-5.

(2) For purposes of IC 12-10-10, the meaning set forth in IC 12-10-10-5.

(3) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-5.

(4) For purposes of IC 12-31, the meaning set forth in IC 12-31-1-13.

SECTION 17. IC 12-7-2-164 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 164. "Resident" has the following meaning:

(1) For purposes of IC 12-10-15, the meaning set forth in IC 12-10-15-5.

(2) For purposes of IC 12-16, except IC 12-16-1, an individual who has actually resided in Indiana for at least ninety (90) days.

(3) For purposes of IC 12-20-8, the meaning set forth in IC 12-20-8-1.

(4) For purposes of IC 12-24-5, the meaning set forth in

IC 12-24-5-1.

(5) For purposes of IC 12-31, the meaning set forth in IC 12-31-1-14.

SECTION 18. IC 12-7-2-172 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 172. (a) Except as provided in ~~subsection~~ **subsections** (b) **and (c),** "secretary" refers to the secretary of family and social services appointed under IC 12-8-1-2.

(b) "Secretary", for purposes of IC 12-13-14, has the meaning set forth in IC 12-13-14-1.

(c) "Secretary", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-15.

SECTION 19. IC 12-7-2-178.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 178.7. "Small employer", for purposes of IC 12-31, has the meaning set forth in IC 12-31-1-16.**

SECTION 20. IC 12-31 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

ARTICLE 31. INDIANA HEALTH COVERAGE

Chapter 1. Definitions

Sec. 1. As used in this article, "authorization" means authorization by the corporation of a health benefit plan as an eligible health benefit plan.

Sec. 2. As used in this article, "carrier" means a person that has a certificate of authority issued under IC 27 to:

(1) issue or deliver a policy of accident and sickness insurance (as defined in IC 27-8-5-1); or

(2) enter into or deliver an individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16);

in Indiana.

Sec. 3. As used in this article, "commissioner" refers to the commissioner of the department of insurance appointed under IC 27-1-1-2.

Sec. 4. As used in this article, "corporation" refers to the Indiana health coverage corporation established by IC 12-31-2-1.

Sec. 5. As used in this article, "eligible health benefit plan" means a health benefit plan that receives authorization to be offered through the program.

Sec. 6. As used in this article, "eligible individual" means a resident who meets the criteria set by the corporation for participation in the program.

Sec. 7. As used in this article, "enrollee" means an individual who participates in the program.

Sec. 8. As used in this article, "fund" refers to the Indiana health coverage trust fund established by IC 12-31-5-1.

Sec. 9. (a) As used in this article, "health benefit plan" means:

(1) a policy;

(2) a contract; or

(3) another arrangement;

that provides coverage for health care services.

(b) The term does not include a plan of worker's compensation coverage.

Sec. 10. (a) As used in this article, "minimum coverage" means coverage of the following under a health benefit plan:

(1) Preventive care.

(2) Inpatient and outpatient hospital and physician care.

(3) Diagnostic laboratory care.

(4) Diagnostic and therapeutic radiological services.

(5) Emergency care.

(6) Mental health services.

(7) Services for alcohol and drug abuse.

(8) Dental services.

(9) Vision services.

(10) Long term rehabilitation treatment.

(11) Health care services required under state or federal law.

(b) The term does not include worker's compensation coverage.

Sec. 11. As used in this article, "premium assistance payment" means a payment of premium made by the corporation to a carrier on behalf of an enrollee for minimum coverage.

Sec. 12. As used in this article, "premium contribution payment" means a payment of premium made by an enrollee for minimum coverage.

Sec. 13. As used in this article, "program" refers to the Indiana health coverage program established by IC 12-31-4-1.

Sec. 14. As used in this article, "resident" means an individual who is legally domiciled and physically present in Indiana for at least nine (9) months of each year.

Sec. 15. As used in this article, "secretary" refers to the secretary of family and social services appointed under IC 12-8-1-2.

Sec. 16. As used in this article, "small employer" means a nongovernmental person that:

(1) is actively engaged in business; and

(2) on at least fifty percent (50%) of the person's working days during the preceding calendar year, employed at least two (2) and not more than fifty (50) employees, the majority of whom work in Indiana.

Chapter 2. Indiana Health Coverage Corporation

Sec. 1. (a) The Indiana health coverage corporation is established as a body corporate and politic, not a state agency but a public instrumentality performing an essential public function.

(b) The purpose of the corporation is to facilitate the availability and choice of, and coverage under, a health benefit plan for eligible individuals and eligible small groups.

(c) The existence of the corporation may not be terminated except by an act of the general assembly.

Sec. 2. (a) The corporation is governed by and consists of eleven (11) members, who must all be residents, as follows:

(1) The secretary, who shall serve as chairperson.

(2) The director of the office of Medicaid policy and planning.

(3) The commissioner.

(4) The commissioner of the department of state revenue.

(5) The commissioner of the state board of accounts.

(6) Six (6) members appointed by the governor as follows:

(A) One (1) who is a member in good standing of the American Academy of Actuaries.

(B) One (1) who is a health economist.

(C) One (1) who represents the interests of small employers.

(D) One (1) who is an employee health benefit plan specialist.

(E) One (1) who is a representative of a health consumer organization.

(F) One (1) who represents organized labor.

Not more than three (3) members appointed under subdivision (6) may be members of the same political party.

(b) A member may not be employed by a carrier.

(c) Members appointed under subsection (a)(6) serve a term of three (3) years. An individual appointed to fill a vacancy serves for the unexpired term. An appointed member is eligible for reappointment.

(d) The corporation shall annually elect one (1) member to serve as vice chairperson.

(e) A member described in subsection (a)(1) through (a)(5) may appoint a designee.

(f) Seven (7) members constitute a quorum. The affirmative vote of at least seven (7) members is necessary for an action of the corporation.

(g) Each member who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(h) Each member who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

Sec. 3. (a) The corporation has all powers necessary to carry out and effectuate the corporation's public and corporate purposes, including the following:

(1) To have perpetual succession as a body corporate and politic and a public instrumentality performing an essential public function.

(2) To adopt, amend, and repeal bylaws and rules under IC 4-22-2 consistent with this article, regulate the corporation's affairs, carry into effect the powers and purposes of the corporation, and conduct the corporation's business.

(3) To sue and be sued in the corporation's name.

(4) To have an official seal.

(5) To maintain a place of business in Indiana.

(6) To make and execute contracts and all other instruments necessary or convenient for the exercise of the corporation's powers and duties under this article.

(7) To employ independent advisers, consultants, and agents as the corporation considers necessary without the approval or consent of a state official.

(8) To procure insurance against loss in connection with the corporation's assets.

(9) To sell, convey, mortgage, pledge, assign, lease, exchange, transfer, and otherwise dispose of the corporation's assets.

(b) The corporation has the following duties:

(1) To develop a plan of operation for the corporation,

including the following:

(A) A process for authorization of eligible health benefit plans to be offered through the program for procurement of eligible health benefit plan coverage to begin not later than October 1, 2008.

(B) A standardized application form and a process for:

(i) determinations of eligibility for participation in the program;

(ii) appeals of eligibility determinations; and

(iii) enrollment of eligible individuals and eligible small groups.

(C) A process for:

(i) annual corporation determinations concerning availability of affordable minimum coverage for residents;

(ii) resident appeals concerning determinations described in item (i); and

(iii) maintenance of records concerning determinations and appeals described in this clause.

(D) A process for appeals of enforcement actions taken and hardship determinations made by the department of state revenue under IC 12-31-3.

(E) A process to:

(i) provide residents, employers, and enrollees with information concerning the program, including eligibility requirements and enrollment procedures; and

(ii) manage program enrollment.

(F) A process for management of a premium payment and collection system for payments made by or on behalf of enrollees, including premium assistance payments.

(2) To seek and receive grant funding from the federal and state government and private entities.

(3) To establish lines of credit and cash and investment accounts to:

(A) receive payments for services provided and appropriations from the state; and

(B) conduct other business under this article.

(4) To determine and approve appropriate use of the corporation's trademarks, brand names, seals, logos, and similar instruments by participating carriers, employers, or other organizations.

(5) To enter into necessary agreements with the department

of state revenue, the secretary, the department of insurance, or a state or federal agency determined necessary by the corporation to implement the program.

(6) To create and provide to the department of state revenue a form for distribution to each individual to whom the department distributes information regarding individual adjusted gross income tax liability, including each individual who filed an adjusted gross income tax return during the most recent calendar year, informing the individual of the requirement that each individual resident establish and maintain health coverage.

(7) To create and publish, before September 30 of each year, a program enrollee premium rate schedule.

(8) Beginning June 1, 2008, to annually review published income levels for the federal income poverty guidelines to determine appropriate eligibility requirements for the program.

(c) The following apply to the corporation:

(1) The members and employees of the corporation are:

(A) under the jurisdiction of and rules adopted by the state ethics commission; and

(B) subject to ethics rules and requirements that apply to the executive branch of state government.

However, the members may adopt additional ethics rules and requirements that are more stringent than those adopted by the state ethics commission.

(2) For purposes of IC 34-13-2, IC 34-13-3, and IC 34-13-4, the members and employees of the corporation are public employees (as defined in IC 34-6-2-38).

(3) Except as specifically provided by law, the corporation and members are subject to IC 5-14-1.5 and IC 5-14-3.

(4) The corporation may adopt a resolution providing that the corporation's employees who are eligible to participate in the public employees' retirement fund under the eligibility requirements set forth in IC 5-10.2 and IC 5-10.3 shall participate in the fund.

(5) The corporation may adopt a resolution to allow the corporation's employees to participate in group insurance and other benefit plans, including the state employees' deferred compensation plan, that are available to state employees.

Sec. 4. The chairperson of the corporation shall, at least annually, report to the governor and, in an electronic format under

IC 5-14-6, to the legislative council concerning the activities of the corporation.

Sec. 5. (a) The board of the corporation shall appoint an executive director of the corporation who shall serve at the pleasure of the board and receive compensation fixed by the board.

(b) The executive director shall:

(1) administer, manage, and direct the program and the employees of the corporation under the direction of the board;

(2) prepare an annual budget and approve all accounts for salaries, allowable expenses of the corporation and of any employee or consultant of the corporation, and expenses incidental to the operation of the corporation;

(3) report to the board concerning all operations under the executive director's supervision and control; and

(4) perform other duties as directed by the board to implement this article.

Sec. 6. The executive director may hire employees necessary to carry out the operation of the program and shall determine employee qualifications, duties, and compensation without the approval of a state official other than the board.

Sec. 7. The corporation shall do the following:

(1) Administer the program.

(2) Enter into an interagency agreement with the department of state revenue to allow the:

(A) corporation to provide to the department of state revenue a list of enrollees and applicants and relevant information, including names, Social Security numbers, and other data required to ensure positive identification of the enrollees and applicants; and

(B) department of state revenue to:

(i) use the data provided under clause (A) to perform the duties required under this article, including verification of family income; and

(ii) provide to the corporation information concerning enrollees and applicants, including employer information, wages received, and gross income.

(3) Beginning not later than January 1, 2009, annually report to the governor, the state board of accounts, the legislative council in an electronic format under IC 5-14-6, and the public concerning the operation and administration of the corporation during the previous year, including the following:

(A) Results of surveys concerning:

(i) the availability of eligible health benefit plans;

(ii) the experience of eligible health benefit plans; and

(iii) individuals who purchase health coverage under health benefit plans outside the program.

(B) Expenses, claims statistics, complaint data, and success of the corporation in meeting the corporation's goals.

(C) An account of all activities, receipts, and expenditures of the corporation during the previous fiscal year.

(D) Significant observations regarding use of the corporation.

(E) Other information considered by the corporation, governor, or legislative council to be informative.

Sec. 8. The corporation may do the following:

(1) Uniformly apply a surcharge to eligible health benefit plans only to pay for administrative and operational expenses of the corporation.

(2) Procure insurance for the corporation and the corporation's members, officers, and employees against liabilities, losses, and expenses incurred under this article or otherwise.

Sec. 9. The corporation may not incur a liability or an obligation that is in excess of the funding provided under this article.

Sec. 10. Upon dissolution, liquidation, or other termination of the corporation:

(1) all rights and properties of the corporation are vested in the state, subject to the rights of lien holders and other creditors; and

(2) net earnings of the corporation, beyond the net earnings necessary for retirement of indebtedness or to implement the program, inure only to the state.

Sec. 11. (a) The corporation or the state board of accounts may at any time:

(1) investigate the affairs of the corporation;

(2) examine the properties and records of the corporation; and

(3) prescribe methods of accounting and the rendering of periodic reports related to projects of the corporation.

(b) The state board of accounts shall audit the corporation on a biennial basis.

Sec. 12. (a) Notwithstanding any other provision of this article, if the corporation determines that it is impossible to implement a

part of this article, the corporation may adopt emergency rules under IC 4-22-2-37.1 to implement that part of this article in a manner determined reasonable by the corporation.

(b) This section expires June 30, 2010.

Chapter 3. Resident Health Coverage Requirement

Sec. 1. (a) This section does not apply to a resident who is exempt under section 2 of this chapter.

(b) Beginning October 1, 2008, a person who is at least eighteen (18) years and sixty-three (63) days of age shall, not later than sixty-three (63) days after becoming a resident, maintain minimum coverage for the resident and any dependent who is a resident and does not have coverage for health care services.

(c) A resident who terminates minimum coverage shall, not more than sixty-three (63) days after termination of the minimum coverage, obtain and maintain minimum coverage for the resident and any dependent who is a resident and does not have coverage for health care services. A resident may not lack minimum coverage for the resident and any dependent who is a resident for a total of more than ninety (90) days during a calendar year.

Sec. 2. (a) A resident who files a sworn affidavit with the resident's adjusted gross state income tax return stating that:

(1) the resident or resident's dependent did not have minimum coverage during the taxable year for which the return is filed; and

(2) the resident's sincerely held religious beliefs are the basis of the resident's or dependent's lack of minimum coverage;

is exempt from the requirements of section 1 of this chapter.

(b) A resident who claims an exemption under subsection (a), but who received or whose dependent received health care services during the taxable year for which the return is filed is:

(1) liable for full payment of charges made for the health care services; and

(2) subject to the penalty described in section 4 of this chapter.

Sec. 3. A resident who files an adjusted gross state income tax return, individually or jointly with a spouse, shall indicate on the return, in a manner prescribed by the department of state revenue, whether the resident complied with section 1 of this chapter during the taxable year for which the return is filed.

Sec. 4. If a resident:

(1) indicates under section 3 of this chapter that the resident did not comply with section 1 of this chapter during the

taxable year; or

(2) does not make an indication under section 3 of this chapter;

the department of state revenue shall, for each month of noncompliance, charge to the resident a penalty equal to one hundred percent (100%) of the minimum premium for minimum coverage for which the resident and any dependents who are residents would have qualified during the taxable year. However, a resident is not liable for a penalty if the resident was not in compliance with section 1 of this chapter for fewer than sixty-four (64) days during the taxable year for which the return is filed.

Sec. 5. The department of state revenue shall deposit penalties collected under this chapter in the fund.

Sec. 6. The department of state revenue, in consultation with the corporation, shall adopt rules under IC 4-22-2 to implement the department of state revenue's duties under this article.

Chapter 4. Indiana Health Coverage Program

Sec. 1. (a) The Indiana health coverage program is established to provide to eligible individuals and eligible small groups, not later than October 1, 2008:

(1) access to coverage under eligible health benefit plans; and

(2) premium assistance payments for minimum coverage based on a sliding scale premium contribution payment schedule.

(b) The program shall be administered by the corporation.

Sec. 2. (a) The corporation shall, not later than July 1, 2007, in consultation with the commissioner, establish criteria that must be met by a health benefit plan to be authorized as an eligible health benefit plan that may be offered through the program.

(b) The criteria established under subsection (a) must include the following:

(1) The health benefit plan is:

(A) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(B) an individual contract (as defined in IC 27-13-1-21); or

(C) a group contract (as defined in IC 27-13-1-16);

filed and available for use according to the applicable requirements of IC 27.

(2) The health benefit plan provides minimum coverage and contains a detailed description of benefits, limitations, and exclusions.

(3) The health benefit plan includes out-of-pocket payments

as follows, to be adjusted annually by the amount of change in the medical component of the Consumer Price Index for All Urban Consumers of the Bureau of Labor Statistics of the United States Department of Labor:

(A) For an enrollee with a family income that is more than three hundred percent (300%) of the federal income poverty level, an annual deductible of one thousand dollars ($1,000) per year with an annual maximum out-of-pocket payment by the enrollee of:

(i) five thousand dollars ($5,000) for family coverage; and

(ii) two thousand five hundred dollars ($2,500) for individual coverage.

(B) For an enrollee with a family income that is less than or equal to three hundred percent (300%) of the federal income poverty level, an annual deductible of five hundred dollars ($500) with an annual maximum out-of-pocket payment by the enrollee of one thousand dollars ($1,000).

(4) The following apply to the premium rating method for the health benefit plan:

(A) The premium rate must be set in the same manner as premiums are set under IC 27 for the same type of policy or contract.

(B) The premium rating method must provide for an adjustment of premium in an enrollee's favor if the enrollee participates in wellness programs established by the program or the carrier.

(C) The premium rating method must provide for a decrease in premium for an enrollee who is not a tobacco user as follows:

(i) A decrease of five percent (5%) for an enrollee with a family income that is less than or equal to three hundred percent (300%) of the federal income poverty level.

(ii) A decrease in an amount determined by the carrier for an enrollee with a family income that is more than three hundred percent (300%) of the federal income poverty level.

(5) The health benefit plan does not allow discrimination in coverage of a health care service based on an enrollee's race, religion, national origin, gender, marital status, actual or expected health status, claims experience, duration of

coverage, personal appearance, political affiliation, source of income, or age.

(6) The health benefit plan is determined by the corporation to provide good quality and value to the consumer.

(7) If the health benefit plan will cover employees of an eligible small employer, the health benefit plan meets the requirements of IC 27-8-15.

(8) The health benefit plan is renewable as required by the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

Sec. 3. (a) A carrier that, as of December 31 of the previous year, had at least one (1) resident covered under an individual or a small employer group policy or contract that:

(1) is regulated under IC 27; and

(2) provides coverage for health care services (as defined in IC 27-13-1-18);

shall, not later than October 31 of the current year, submit to the corporation a health benefit plan that meets the criteria established under section 2 of this chapter for authorization as an eligible health benefit plan.

(b) The corporation shall authorize a health benefit plan that meets the criteria established under this chapter as an eligible health benefit plan.

Sec. 4. (a) The corporation shall establish:

(1) criteria for eligibility of a:

(A) resident for premium assistance payments; and

(B) resident or a small employer for participation in an eligible health benefit plan; and

(2) a sliding scale schedule for premium contribution payments for residents.

(b) The criteria for eligibility of a resident established under subsection (a)(1) must include the following:

(1) A resident is eligible to participate in the program if the:

(A) resident is not eligible for coverage under a state or federal health coverage program;

(B) resident does not have coverage under an individual or a group health benefit plan available to the resident; and

(C) resident or resident's family member has not accepted a financial incentive from an employer to decline coverage under the employer's employer sponsored health benefit plan.

(2) Any additional criteria determined by the corporation to

be reasonable.

(c) The criteria for eligibility of a small employer under subsection (a)(1)(B) must include criteria specifying that, as a condition of participation in the program, the small employer:

(1) may not offer a health benefit plan to the small employer's employees other than through the program;

(2) may determine during a period designated by the corporation and subject to applicable law, the:

(A) criteria for employee eligibility, enrollment, and participation in the program; and

(B) amount of contributions to be made by the small employer for employee coverage under the eligible health benefit plan;

(3) shall offer to the small employer's employees health coverage through a cafeteria plan under 26 U.S.C. 125;

(4) shall participate in payroll deduction of eligible health benefit plan premium payments by the small employer's employees to benefit from deductibility of gross income under 26 U.S.C. 104, 26 U.S.C. 105, 26 U.S.C. 106, and 26 U.S.C. 125; and

(5) shall make available for confidential review by the executive director the small employer's documents, records, or information that the corporation reasonably determines necessary to verify:

(A) the small employer's compliance with applicable laws relating to group health benefit plans; and

(B) the eligibility, under the terms of the eligible health benefit plan, of individuals enrolled in the small employer's health benefit plan.

(d) The criteria specified in subsection (b)(1)(C) may be waived for a resident who is described in subsection (b)(1)(C) and is eligible for coverage under an employer sponsored health benefit plan, but is determined by the corporation to be unable to afford the coverage, if the resident's employer agrees to pay to the program the amount that the employer would pay toward the resident's coverage under the employer sponsored health benefit plan. An amount paid by an employer under this subsection must first be used to offset a premium assistance payment made by the program for the resident's coverage under the program, with any remainder used to offset the resident's premium contribution payment.

Sec. 5. A resident or small employer may apply for participation

in the program. The corporation shall provide in writing to a resident or small employer that applies:

(1) a determination regarding the resident's or small employer's eligibility for participation; and

(2) if the determination is denial of eligibility, the:

(A) reasons for denial; and

(B) procedure for appeal of the denial.

Sec. 6. (a) Premium contribution payments established under section 4(a)(2) of this chapter apply only to enrollees who are not members of a small employer group that participates in the program.

(b) The sliding scale schedule for premium contribution payments established under section 4(a)(2) of this chapter must:

(1) be annually updated and published by the corporation not later than September 1 of each year; and

(2) provide for enrollee responsibility for a premium contribution payment according to the following parameters:

(A) For an enrollee with a family income that is more than three hundred percent (300%) of the federal income poverty level, the enrollee shall pay one hundred percent (100%) of the premium.

(B) For an enrollee with a family income that is more than two hundred percent (200%) but not more than three hundred percent (300%) of the federal income poverty level, the enrollee shall pay not more than ten percent (10%) of the enrollee's family income.

(C) For an enrollee with a family income that is less than or equal to two hundred percent (200%) of the federal income poverty level, the enrollee shall pay not more than five percent (5%) of the enrollee's family income.

Sec. 7. The premium charged by a carrier for coverage of an enrollee under an eligible health benefit plan must be paid as follows:

(1) For an enrollee who is not a member of a small employer group that participates in the program, by a combination of:

(A) the premium contribution payment established for the enrollee according to the sliding scale schedule established under section 1 of this chapter;

(B) any amount paid by an employer; and

(C) a premium assistance payment made by the corporation.

(2) For an enrollee who is a member of a small employer

group that participates in the program, by a combination of:

(A) the premium contribution established for the enrollee by the small employer; and

(B) the premium contribution established for the small employer by the small employer;

under section 4(c) of this chapter.

Sec. 8. An eligible individual or eligible small group may not be denied coverage under an eligible health benefit plan offered through the program.

Sec. 9. Premium assistance payments must be made directly by the corporation to eligible health benefit plans.

Sec. 10. (a) If an insurance producer licensed under IC 27-1-15.6 enrolls an eligible individual or eligible small group in an eligible health benefit plan, the carrier that issues the eligible health benefit plan shall pay to the insurance producer a commission determined by the corporation.

(b) In determining a commission described in subsection (a), the corporation shall consider rates of commissions customarily paid to insurance producers in relation to health benefit plans delivered under IC 27.

Sec. 11. A participating carrier shall provide reports to the corporation as determined by the corporation to be necessary to enable the executive director to carry out the executive director's duties under this article.

Sec. 12. The corporation may terminate an eligible health benefit plan from the program only after notice to the carrier.

Sec. 13. Participation in the program by an eligible individual or eligible small group ceases if coverage is canceled due to the eligible individual's or eligible small group's:

(1) failure to pay the required premium contribution payment;

(2) commission of fraud or misrepresentation; or

(3) failure to materially comply with another requirement for participation in the program.

Chapter 5. Indiana Health Coverage Trust Fund

Sec. 1. The Indiana health coverage trust fund is established to provide funding for implementation of the duties of the corporation under this article and participation by eligible individuals and eligible small groups in the program. The fund shall be administered by the corporation.

Sec. 2. The expenses of administering the fund shall be paid from money in the fund.

Sec. 3. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from the investments shall be deposited in the fund.

Sec. 4. Money in the fund is annually appropriated for the purposes described in this chapter.

Sec. 5. Money in the fund at the end of a state fiscal year does not revert to the state general fund.

Sec. 6. Money received by the corporation from taxes, appropriations, donations, penalties, fees, surcharges, or another source must be deposited in the fund.

Sec. 7. There is annually appropriated to the fund from the state general fund the amount necessary for the operation of the program.

SECTION 21. IC 27-8-5-2, AS AMENDED BY P.L.125-2005, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy ~~may~~ **must** insure, originally or by subsequent amendment, upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age, any two (2) or more eligible members of that family, including husband, wife, dependent children, or any children ~~under a specified age, which shall not exceed nineteen (19)~~ **who are less than twenty-five (25)** years **of age,** and any other person dependent upon the policyholder, **for at least two (2) years after the person's dependency ends.**

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any,

and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) If an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child:

(A) while the child is and continues to be both:

~~(A)~~ **(i)** incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

~~(B)~~ **(ii)** chiefly dependent upon the policyholder for support and maintenance; **and**

(B) for at least two (2) years after the child ceases to meet the requirements of clause (A).

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who is a mentally retarded or

mentally or physically disabled child where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

SECTION 22. IC 27-8-5-19, AS AMENDED BY P.L.127-2006, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the

policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for

which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the enrollment date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the enrollment date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the enrollment date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A

provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under

clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid in accordance with IC 27-8-5.7; and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required

by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child:

(A) while the child is:

~~(A)~~ **(i)** incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

~~(B)~~ **(ii)** chiefly dependent upon the group member for support and maintenance; **and**

(B) for at least two (2) years after the child ceases to meet the requirements of clause (A).

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded or mentally or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection (c)(8); and

(2) request the certificate in paper form.

SECTION 23. IC 27-8-5-28 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed, unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the later of:**

(1) the date that the child becomes twenty-five (25) years of age; or

(2) two (2) years after the end of a physically or mentally disabling condition that causes the child to be dependent upon the insured.

SECTION 24. IC 27-13-7-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

(1) The name and address of the health maintenance organization.

(2) Eligibility requirements.

(3) Benefits and services within the service area.

(4) Emergency care benefits and services.

(5) Any out-of-area benefits and services.

(6) Copayments, deductibles, and other out-of-pocket costs.

(7) Limitations and exclusions.

(8) Enrollee termination provisions.

(9) Any enrollee reinstatement provisions.

(10) Claims procedures.

(11) Enrollee grievance procedures.

(12) Continuation of coverage provisions.

(13) Conversion provisions.

(14) Extension of benefit provisions.

(15) Coordination of benefit provisions.

(16) Any subrogation provisions.

(17) A description of the service area.

(18) The entire contract provisions.

(19) The term of the coverage provided by the contract.

(20) Any right of cancellation of the group or individual contract holder.

(21) Right of renewal provisions.

(22) Provisions regarding reinstatement of a group or an individual contract holder.

(23) Grace period provisions.

(24) A provision on conformity with state law.

(25) A provision or provisions that comply with the:

(A) guaranteed renewability; and

(B) group portability;

requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(26) That the contract provides, upon request of the subscriber, coverage for a child of the subscriber until the later of:

(A) the date the child becomes twenty-five (25) years of age; or

(B) two (2) years after the end of a physically or mentally disabling condition that causes the child to be dependent upon the subscriber.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

SECTION 25. IC 31-19-26-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) When a petition for adoption is filed seeking a subsidy and the payment of a subsidy is ordered by the court, **or a subsidy is required under section 3(a) of this chapter,** the order **or adoption decree** must contain the following information:

(1) Whether a subsidy:

(A) will be paid under section 2 ~~or 3~~ of this chapter;

(B) is required under section 3(a) of this chapter; or

(C) satisfies both **clauses (A) and (B).**

(2) The amount of ~~each~~ **a** subsidy to be paid **under section 2 of this chapter.**

(3) If a subsidy ~~will be paid~~ **is required** under ~~section 3~~ **section 3(a)** of this chapter, the condition or cause covered by the subsidy.

(4) Any condition for the continued payment of a subsidy other than a requirement set forth in this chapter.

(b) **Except as provided in section 3 of this chapter,** the county office of family and children of the county responsible for foster care of an adoptive child:

(1) may be ordered to pay ~~either or both of the subsidies~~ **the subsidy under section 2 of this chapter; and**

(2) shall pay a subsidy required under **section 3 of** this chapter; to the adoptive parents or designated payees to the extent that money is available.

SECTION 26. IC 31-19-26-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. **(a)** The ~~court may order the department to~~ **county office of family and children of the county responsible for foster care of an adoptive child shall** pay a subsidy for the medical, surgical, hospital, and related expenses for an adoptive child due to the physical, mental, emotional, or medical condition of the child if:

(1) the condition or the cause of the condition existed before the petition for adoption was filed; ~~and~~

(2) the expenses related to treatment of the condition are paid by the state or a local unit of government before the adoption; and

~~(2)~~ **(3)** payments from insurance or public money to treat the condition or cause of the condition are not available to the adoptive child or adoptive parents.

(b) The county office of family and children of the county responsible for foster care of an adoptive child shall pay a subsidy for the medical, surgical, hospital, and related expenses for an adoptive child due to a physical, a mental, an emotional, or a medical condition of the child of which evidence appears after the child is adopted if:

(1) the condition or the cause of the condition existed before the petition for adoption was filed, as determined by the child's treating physician; and

(2) payments from insurance or public money to treat the condition or cause of the condition are not available to the adoptive child or adoptive parents.

(c) If funding for subsidies is not available through the county office of family and children as required under subsections (a) and (b), the department of child services established by IC 31-25-1-1 shall pay the subsidy.

(d) The amount of the subsidy required under subsection (a) or (b) must be equal to the amount that would be paid for the medical, surgical, hospital, and related expenses under the Medicaid

program under IC 12-15.

(e) A person aggrieved by an agency action under this section may petition for administrative review under IC 4-21.5-3-7.

SECTION 27. IC 31-19-26-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. (a) Subject to subsection (b), the subsidies under sections 2 and 3 of this chapter continue:

(1) until:

(A) the child becomes eighteen (18) years of age;

(B) the child becomes emancipated;

(C) the child dies;

(D) the child's adoption is terminated; or

(E) further order of court;

whichever occurs first; and

(2) although the adoptive parents leave the jurisdiction of the court.

(b) The court may order a subsidy granted **or required** under this chapter to continue until the adoptive child becomes twenty-one (21) years of age. The court may issue an order under this subsection if:

(1) the adoptive child files a petition for the order; and

(2) the court determines that the child is enrolled in:

(A) a secondary school;

(B) a college or university; or

(C) a course of vocational training leading to gainful employment.

SECTION 28. IC 31-19-26-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 5. (a) As a condition for continuation of the subsidies, the court shall require the adoptive parents to file a sworn report with the court, with an additional copy to be filed with the county office of family and children making the payments of aid, at least one (1) time each year, stating:

(1) the location of the parents; and

(2) the location and condition of the child.

(b) The court or the county office of family and children may request confirmation of the veracity of the report required by subsection (a) from any governmental agency that provides services in the area of Indiana in which the child resides. On the basis of the report or information received by the court indicating changed conditions, the court may:

(1) continue;

(2) increase;

(3) reduce; or

(4) discontinue;

the subsidy by order of the court. **However, a court may not reduce or discontinue a subsidy under this section if the subsidy is required under section 3 of this chapter.**

SECTION 29. [EFFECTIVE JULY 1, 2007] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning.**

(b) Before September 1, 2007, the office shall apply to the United States Department of Health and Human Services for a demonstration waiver under Section 1115 of the federal Social Security Act to allow coverage for minimum coverage (as defined in IC 12-31-1-10) for residents (as defined in IC 12-31-1-14, as added by this act):

(1) with family incomes less than three hundred percent (300%) of the federal income poverty level; and

(2) who are less than sixty-five (65) years of age.

(c) The office may not implement the waiver until the office files an affidavit with the governor attesting that the federal waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the waiver is approved.

(d) If the office receives a waiver applied for under subsection (b) and the governor receives the affidavit filed under subsection (c), the office shall implement the waiver not more than sixty (60) days after the governor receives the affidavit.

SECTION 30. [EFFECTIVE JULY 1, 2007] **(a) The definitions in IC 12-31-1, as added by this act, apply throughout this SECTION.**

(b) The corporation and each carrier that provides coverage under an eligible health benefit plan shall provide for an open enrollment period for eligible individuals beginning September 1, 2008, and ending November 30, 2008. A carrier may not impose a preexisting condition or waiting period limitation or exclusion on the coverage of an eligible individual who enrolls in an eligible health benefit plan during the open enrollment period.

(c) This SECTION expires December 31, 2010.

SECTION 31. [EFFECTIVE JULY 1, 2007] **(a) The definitions in IC 12-31-1, as added by this act, apply throughout this SECTION.**

(b) Notwithstanding any other law, the secretary shall, in coordination with other appropriate state agencies, develop an implementation plan and a corresponding time line detailing monthly action steps toward implementing the requirements of IC 12-31, as added by this act.

(c) The implementation plan developed under this SECTION must:

(1) be developed in cooperation with stakeholders, including consumers, health care providers, carriers including Medicaid managed care organizations, and advocacy and business organizations;

(2) be reported to the legislative council in an electronic format under IC 5-14-6 not later than September 30, 2007, and then on a bimonthly basis; and

(3) include all regulatory and operational requirements specified in this act, including the following:

(A) The projected and actual monthly health coverage enrollment levels by coverage type, including:

(i) Medicaid;

(ii) coverage under eligible health benefit plans, or other health benefit plans available due to premium contribution payments, through the program for residents with family incomes of not more than three hundred percent (300%) of the federal income poverty level; and

(iii) coverage under health benefit plans available for residents with family incomes greater than three hundred percent (300%) of the federal income poverty level.

(B) Monthly figures reflecting the number of uninsured residents.

(C) Health coverage market reforms in Indiana, including the availability of affordable health coverage.

(D) The implementation of and timetable for Medicaid expansions.

(E) The development, authorization, and affordability of eligible health benefit plans and premium assistance payments for residents with family incomes of not more than three hundred percent (300%) of the federal income poverty level.

(F) The establishment of the corporation and implementation of the corporation's functions.

(G) The development of a collaborative program marketing and outreach plan, with accompanying budget and implementation time line.

(H) The development of the program, including the sliding scale premium assistance payment schedule and premium

contribution payment collection process.

(I) An electronic connection and collaborative processes between the corporation and other agencies to facilitate health coverage through the program.

SECTION 32. [EFFECTIVE JULY 1, 2007] **(a) IC 27-8-5-2, as amended by this act, applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.**

(b) IC 27-8-5-19, as amended by this act, applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

(c) IC 27-13-7-3, as amended by this act, applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

SECTION 33. [EFFECTIVE JANUARY 1, 2008] **IC 6-3.1-31, as added by this act, applies to taxable years beginning after December 31, 2007.**